C-Modules

INTRODUCTION

MODULE

0 1 2 3 4 5

A LEARNING PACKAGE FOR SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

PRACTITIONER'S HANDBOOK

C-CHANGE
COMMUNICATION FOR CHANGE

C-Modules: A Learning Package for Social and Behavior Change Communication (SBCC)

Communication for Change (C-Change) Project
Version 3

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C-Change is implemented by FHI 360 and its partners: CARE; Internews; Ohio University; IDEO; Center for Media Studies, India; New Concept, India; Soul City, South Africa; Social Surveys, South Africa; and Straight Talk, Uganda.

Overview

This introductory module is the foundation for the rest of the *C-Modules* (Module 1–5). This introductory module explores concepts and principles referred to throughout this learning package on social and behavior change communication (SBCC). It is therefore an essential starting point.

Sessions

A Note on Formatting

In the *C-Modules,* the names of theories and models are in **bolded, dark blue text;** concepts are in *dark blue italics.*

Module 0, Session 1: SBCC Defined

What Is Social and Behavior Change Communication (SBCC)?

SBCC is the systematic application of interactive, theory-based, and research-driven communication processes and strategies to address *tipping points* for change at the individual, community, and social levels. A tipping point refers to the dynamics of social change, where trends rapidly evolve into permanent changes. It can be driven by a naturally occurring event or a strong determinant for change—such as political will that provides the final push to "tip over" barriers to change. Tipping points describe how momentum builds up to a point where change gains strength and becomes unstoppable.

Why the Shift from Behavior Change Communication (BCC) to SBCC?

Over the years, there has been a shift in how health and development programs think about human behaviors. Approaches to behavior change have expanded beyond a focus on the individual in order to emphasize sustainable, social change. (This will be explored in more depth in session 4, starting on page 9). **SBCC looks at a problem from multiple sides** by analyzing personal, societal, and environmental factors to find the most effective tipping points for sustainable change. While BCC can achieve individual empowerment, SBCC is also using strategies that influence the physical, socio-economic, and cultural environment to facilitate healthy norms and choices and remove barriers to them. In some situations, advocacy or social mobilization for policy change may support stronger and more immediate permanent change than campaigns that target individual behaviors. SBCC methods aim to improve advocacy or mobilization for social action, along with BCC for personal change. BCC is thus part of SBCC, while SBCC builds on BCC.

Below is an example of what SBCC might look like in the real world:

In Albania, young people often have sex without protection against pregnancy or sexually transmitted infections. Modern contraceptive methods (MCMs) are largely available but underused for a number of reasons, including misunderstandings about how they work; limited conversations between young couples; and poor connections between youth and pharmacists, the main providers of modern methods. A recent SBCC effort by C-Change focused simultaneously on different audiences—urban university youth, pharmacists, and journalists—to bring about holistic change. Attention was paid to the behaviors of young men and women and of contraceptive service providers, as well as how contraceptives were portrayed by the media. A mix of communication channels was selected to achieve specific objectives. A mass media campaign complemented peer-to-peer work with young men and women. C-Change geared interpersonal skills-training interventions to pharmacists and reproductive health training to journalists. Implementation focused on maintaining partnerships, selecting the right staff, addressing gender issues, sticking to a realistic budget, planning carefully for materials production, and monitoring quality.

The end-of-project evaluation demonstrated significant improvement in MCM awareness among university students. At endline, 75 percent of respondents could name three or more MCMs, compared to 16 percent at baseline and 54 percent at endline in the comparison site, where no interpersonal communication training of providers or peer education took place. Interpersonal communication also improved significantly, in terms of young people talking with a sexual partner in the past three months about avoiding pregnancy (54 percent in intervention sites versus 24 percent at baseline and 45 percent in the comparison site at endline). Current use of MCMs increased from 31 percent at baseline to 47 percent at endline. The evaluation study findings demonstrate the success of the multi-component SBCC project in meeting its family planning objectives (Nanda, DeNegri, Boci, and Volle 2011).

Module 0, Session 2: This Course

Modules 0 through 5 are designed for practitioners who want to build their own capacity to develop, implement, monitor, and replan quality SBCC programs and contribute to collective learning about SBCC.

By the end of this course, participants will have:
- practiced the five systematic steps of SBCC—from planning through implementation and re-planning
- used C-Change's Socio-Ecological Model for Change and SBCC theories, models, and approaches to analyze how change happens
- explored how advocacy, social mobilization, and BCC strategies can work together

Modules 1 through 5 each address one of the steps of C-Planning. On the next page is an overview of all the tools in Modules 0 through 5—worksheets, checklists, templates, and graphics—that can help practitioners to gain understanding and apply SBCC concepts in their programmatic work.

Overview of C-Tools: Worksheets, Checklists, and Graphics Included in Practitioner's Handbooks

MODULE 0 Tools: Introduction	
Graphics	**Worksheets, Checklists. and Templates**
• C-Planning • Socio-Ecological Model for Change • The Theoretical Base of the Socio-Ecological Model and Concepts of Selected SBCC Theories • Three Key Strategies of SBCC	• Worksheet: Current Projects • Worksheet: A Socio-Ecological Model for Change • Worksheet: Key Strategies of SBCC • Worksheet: Ten SBCC Principles

MODULE 1 Tools: Understanding the Situation			
Graphics	**Worksheets, Checklists, and Templates**		
• The First Step of a Planning Process for SBCC—Understanding the Situation • Example Problem Tree: HIV and AIDS in Southern Africa • Example People Analysis: HIV and AIDS in Southern Africa • Unpacking the Socio-Ecological Model for Change • Where Formative Research Fits into SBCC	• Worksheet: Problem Tree • Worksheet: People Analysis • Worksheet: A Gender Perspective • Worksheet: Context Analysis	• Worksheet: Existing Research Inventory • Worksheet: Formative Research Gaps and How to Fill Them • Worksheet: Draft Research Plan	• Worksheet: Matrix of Partners, Allies, and Gatekeepers • Worksheet: Summary of Your Analysis • Worksheet: What Is Your Theory of Change?

MODULE 2 Tools: Focusing and Designing			
Graphics	**Worksheets, Checklists, and Templates**		
• The Second Step of a Planning Process for SBCC—Focusing and Designing • A Socio-Ecological Model • The Theoretical Base of the Socio-Ecological Model and Concepts of Selected SBCC Theories • Three Key Strategies for SBCC • Where M&E Fits into SBCC	• Worksheet: Communication Strategy Outline • Checklist: Audience Segmentation • Worksheet: Audience Segmentation Map • Checklist: Audience Prioritization • Worksheet: Audience Profile • Worksheet: Matrix for Change • Worksheet: SMART Communication Objectives	• Worksheet: Strategic Approach • Worksheet: Positioning • Worksheet: Activity, Channel, and Material Mix • Worksheet: Deciding on the Right Channel and Material Mix • Worksheet: Channel and Material Selection	• Worksheet: Scenario to Create an Environment of Change • Worksheet: Draft List of Activities with Matching Channels and Materials • Worksheet: Draft Implementation Plan • Worksheet: Users and Uses of M&E Data

MODULE 3 Tools: Creating

Graphics	Worksheets, Checklists, and Templates		
• The Third Step of a Planning Process for SBCC—Creating • Relationship Between the Strategy and Creative Brief	• Worksheet: What is the New Material/Activity Based on? • Worksheet: Inventory of Existing Materials and Activities • Worksheet: Analyzing Examples of SBCC Materials	• Worksheet: Creative Brief for Your Activity/Material • Worksheet: Effective Messages • Checklist: Basic Principles of Message Development	• Worksheet: Storyboard Outline • Checklist: Drafting Print Materials • Checklist: Quality Messages and Materials • Worksheet: Draft Production Timeline

MODULE 4 Tools: Implementing and Monitoring

Graphics	Worksheets, Checklists, and Templates		
• The Fourth Step of a Planning Process for SBCC—Implementing and Monitoring • Three Key Strategies of SBCC • Where Monitoring Fits into SBCC	• Worksheet: Detailed Workplan • Checklist: Gender Issues in Planning, Implementation, and Evaluation • Checklist: Project Staffing Plan • Worksheet: SBCC Coordination • Worksheet: Supervisory Tool • Checklist: Successful Partnership in SBCC	• Worksheet: SBCC Budgeting Tool • Worksheet: How to Make Team Decisions on Budget Priorities • Worksheet: Plan to Identify and Approach Resource Providers • Worksheet: How to Make Team Decisions on Sequence, Timing, and Synergy	• Worksheet: Template to Track Distribution Points and Production Needs (per Material or Activity) • Worksheet: Quality in SBCC • Worksheet: Plan to Monitor Process and Quality of All SBCC Materials and Activities

MODULE 5 Tools: Evaluating and Replanning

Graphics	Worksheets, Checklists, and Templates		
• Where Research Fits into SBCC • A Simplified M&E Framework	• Worksheet: Users and Uses of M&E Data • Worksheet: Key Decisions before Data Collection • Worksheet: Selecting M&E Questions • Worksheet: Selecting Monitoring Indicators • Worksheet: Selecting Evaluation Indicators	• Worksheet: Evaluation Research Design Sketch • Checklist: Designing M&E Tools • Worksheet: Pulling it all Together—Scenarios • Worksheet: Selecting the Best M&E Methods and Tools for Your Program • Worksheet: Data Quality Scenarios	• Worksheet: Your Simplified Data Analysis Plan • Worksheet: Data Interpretation and Presentation Exercise • Worksheet: M&E Plan Template • Worksheet: Replanning Exercise

Module 0, Session 3: Current Projects

WORKSHEET: Current Projects

Directions: Use this worksheet to briefly describe a recent or current communication project in which you've been involved.

What's the challenge or problem addressed by the project?

What processes have you followed during the development and/or implementation of the project?

What strategies have you used to implement the project?

What theories or models, if any, have guided this work?

What worked well and what's been a challenge during the development and/or implementation of the project?

As much as possible during this course, apply SBCC concepts and tools to real-life examples like the one completed above.

Module 0, Session 4: Characteristics of SBCC

SBCC has Three Characteristics:

1. **SBCC is a process.**
   - It is interactive, researched, planned, and strategic.
   - It aims to change social conditions and individual behaviors.

2. **SBCC applies a comprehensive, socio-ecological model** to identify effective *tipping points* for change by examining:
   - *individual knowledge, motivation,* and other behavior change communication concepts
   - *social, cultural, and gender norms, skills, physical and economic access,* and legislation that contribute to an enabling environment

3. **SBCC uses three key strategies:**
   - *advocacy*—to raise resources as well as political and social leadership commitment to development actions and goals
   - *social mobilization*—for wider participation, coalition building, and ownership, including community mobilization
   - *behavior change communication*—for changes in knowledge, attitudes, and practices among specific audiences

Characteristic 1: SBCC Is a Process

The SBCC process includes five steps shown in the C-Planning graphic:
1. Understanding the Situation
2. Focusing and Designing Your Strategy
3. Creating Interventions and Materials
4. Implementing and Monitoring
5. Evaluating and Replanning

All five steps of C-Planning draw on the previous step and prepare practitioners for subsequent steps. C-Planning provides a structure for Modules 1 through 5.

SOURCE: Adapted from: Health Communication Partnership, CCP at JHU (2003) the P-Process; McKee et al (2000) the ACADA Model; Parker, Dalrymple, and Durden (1998) The Integrated Strategy Wheel; Roberts et al (1995) the Tool Box for Building Health Communication Capacity; and National Cancer Institute (1989) Health Communication Program Cycle.

Characteristic 2: SBCC Uses a Socio-Ecological Model for Change

Theories and models have guided development communication and provide road maps for studying and addressing development issues.[1]

- A *theory* is a systematic and organized explanation of events or situations. It tests assumptions. Theories are developed from a set of concepts (or constructs) that explain and predict events and situations and clarify the relationship between different variables. For example, the **Agenda-Setting Theory** argues that media coverage shapes what audiences think. (More details are in the Appendix that begins on page 25.)
- A *model* is usually less specific than a theory, and often draws upon multiple theories to try to explain a given phenomenon. For example, the **Health Belief Model** suggests that individual beliefs affect behaviors. (More details are in the Appendix that begins on page 25.)

Theories and models help practitioners understand a given problem and its possible determinants to identify effective actions to address problems and barriers. They also guide the design and implementation of evidence-based programs and evaluations. It should be noted that adequately addressing an issue may require more than one theory, and that no one theory is suitable for all cases (Glanz, Rimer, and Su 2005).

Theories and models address human behaviors on one of *three possible levels of change:* individual, interpersonal, or community/social. The chart below describes the level of change, the main level of change processes in human behavior, and what could be modified at each of those levels.

Level of Change	Change Process	Targets of Change
Individual	Psychological	Personal behaviors
Interpersonal	Psycho-social	How the person interacts with his or her social network
Community/social	Socio-cultural	Dominant norms at community and societal levels

* Adapted from McKee, Manoncourt, Yoon, and Carnegie (2000)

Over the years, there has been a shift in thinking about human behavior. For example, early in the HIV and AIDS epidemic, communication practitioners largely believed that giving correct information about HIV transmission and prevention would result in behavior change. While providing correct information is an important part of behavior change, information alone has proved to be insufficient. Practitioners now acknowledge four key facts about human behavior:

1. People give meaning to information based on the context in which they live.
2. Culture and networks influence people's behavior.
3. People can't always control the issues that determine their behavior.
4. People's decisions about health and well-being compete with other priorities.

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[1] For more information on theory, see the Appendix, "The Theoretical Base of the Socio-Ecological Model" (page 25) and review C-Change's PowerPoint on SBCC Theory in *Additional Resources*, part of the packet of the *C-Modules*.

The shift from a focus on the individual to comprehensive approaches that consider social conditions resulted in a model that tries to consolidate conceptual thinking into an ecological perspective that looks at the relationships between individuals and their environments. C-Change's Socio-Ecological Model for Change views social and behavior change as a product of multiple, overlapping levels of influence—individual, interpersonal, community, and organizational—as well as political and environmental factors (Sallis, Owen, and Fisher 2008). This model helps to combine individual change with the aim to influence the social context in which the individual operates.

Throughout the *C-Modules*, the Socio-Ecological Model for Change is used to find the strongest tipping point for change. A *tipping point* can be driven by a naturally occurring event or a strong determinant for change, such as political will that provides the final push to "tip over" barriers to change or provide the sudden energy for change. *Tipping points* describe how momentum builds up to a point where change gains strength and becomes unstoppable. This model underscores the need to go beyond ad hoc interventions to coordinated social change efforts.

> **Theory Corner: Ecological Models of Change**
>
> **Ecological models of change** gained influence when practitioners realized the limitations of existing models that focus exclusively on individuals with the assumption that they are in full control of their behaviors and living conditions. As Glass and McAtee noted (2006): "The study of health behavior in isolation from the broader social and environmental context is incomplete and has contributed to disappointing results from experiments in behavior change."
>
> An *ecological perspective* considers:
> 1. Multiple levels of factors influence social and behavior change.
> 2. Levels of factors can include individual, interpersonal, community/organizational, and national/political/environmental.
> 3. Influences interact across levels.
> 4. Multi-level interventions addressing various influences are more robust and potentially sustainable than individual-level interventions.
>
> (Adapted from Sallis, Owen, and Fisher 2008.)

Examples of Behavioral Theories and Models

By looking at theories and models, practitioners can begin to understand or further reinforce "what, why, and how health problems should be addressed" (Glanz, Rimer, and Su 2005). Below are some selected theories for each level of change that can help practitioners start thinking about how theory can assist their communication work.

Directions: Choose one of the theories listed below that has guided your work in the past.
- What has been useful about this theory for the program?
- How has it fallen short of what was needed to effectively understand and change behaviors?

Individual Level

Stages of Change Theory was conceptualized as a five-stage process related to a person's readiness to change: 1) *pre-contemplation*, 2) *contemplation,* 3) *preparation,* 4) *action,* and 5) *maintenance.* People progress through these stages at varying rates, often moving back and forth along the continuum a number of times before attaining the goal of maintenance. Programs using this theory consider the following questions:
- At which stage is the audience with respect to the desired action—e.g., adoption of hand washing?
- What information, support, or messages do audience members need at that stage?

Interpersonal Level

Theory of Social Learning posits that people learn how to behave by: 1) *observing the actions of others;* 2) *observing apparent consequences of those actions;* 3) *checking those consequences for their own lives*; and 4) *rehearsing and trying out those actions themselves.* A communication program using this theory builds on key individuals in the community modeling the desired behaviors. A key concept to measure would be the individual's level of self-efficacy by answering the following question:
- To what degree do people believe they have the *ability* by their own actions to achieve desired results, e.g., correct condom use?

Community/Social Level

Diffusion of Innovations Theory describes how new ideas and practices—innovations or technologies, such as the use of indoor residual spraying for malaria prevention—are spread through *social networks* over time. This spread depends on the *perceived characteristics* of the innovation and *characteristics of the social network*. Research would try to answer the following questions about existing social networks:
- How connected are different networks?
- How large are the different networks?
- Who are the leaders and innovators in those networks?

Remember, for the **Diffusion of Innovations Theory,** it is important to find out what the target population thinks of the new ideas and behaviors and for programs to include messages that address any concerns about the innovation or technology.

GRAPHIC: Socio-Ecological Model for Change

SBCC applies a socio-ecological model that examines several levels of influence to provide insight on the causes of problems and find *tipping points* for change. C-Change's Socio-Ecological Model for Change, applied throughout the *C-Modules,* is a combination of ecological models and sociological and psychological factors that will assist programs engaged in analysis and planning. It has two parts:

1. ***Levels of analysis***, the rings of the model, represent both domains of influence as well as the people involved in each level.
2. ***Cross-cutting factors*** in the triangle influence each of the actors and structures in the rings.

The ***levels of analysis*** (represented by the rings) are
- the individual most affected by the issue (or self)
- direct influencers on the individual (represented by two rings):
  - o the interpersonal: partners, family, and peers
  - o the community: organizations, service structures, providers, as well as products available

Both the interpersonal and community rings shape community and gender norms, access to and demand for community resources, and existing services.
- Indirect influences make up the outer enabling environment. Components may facilitate or hinder change, and include national policies and legislation, political forces, prevailing economic conditions, the private sector, religion, technology, and the natural environment. Actors such as national government, business, and faith and movement leaders are often targets for advocacy and social mobilization activities.

Socio-Ecological Model for Change
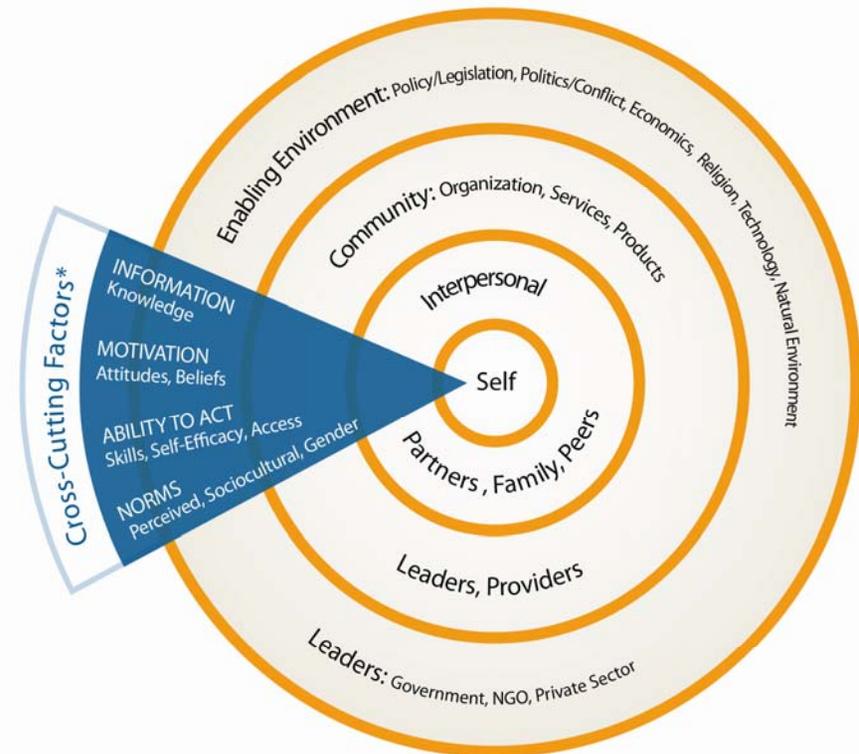
*These concepts apply to all levels (people, organizations, and institutions). They were originally developed for the individual level.

SOURCE: Adapted from McKee, Manoncourt, Chin and Carnegie (2000)

Each level of analysis and the actors/institutions within each level are influenced by several **cross-cutting factors** (the triangle of influence). It is on these cross-cutting factors that SBCC interventions may be able to generate change. These factors may act in isolation or in combination. To help identify them, they are in four large categories: information, motivation, ability to act, and norms.

People need *information* that is timely, accessible, and relevant. When looking at information, SBCC practitioners consider the level of *knowledge* held by a person or group—e.g., about modern contraceptives and their side effects. With such information, some individuals, groups, or communities may be empowered to act. For most people, information is not enough to prompt change.

People require *motivation*, which is often determined by their *attitudes, beliefs, or perceptions of the benefits, risks, or seriousness* of the issues that programs are trying to change—e.g., attitudes toward condom use, beliefs about the benefits of family planning, or risk perceptions of HIV infection. Motivation can be affected by SBCC methods or strategies, such as effective counseling, peer education, entertaining radio broadcasts, or TV programs. If done well, such communication can foster individual attitude and behavior change, as well as social norm change.

However, even motivation may not be enough. For instance, few women and girls in the countries hardest hit by HIV and AIDS have the power to negotiate the time and conditions for having sex, including condom use, or they may lack the funds to buy condoms. They need the *ability to act* in particular circumstances. Practitioners should look at the actual skills self-efficacy (or collective efficacy), and access of the actors.
- *Skills* include psychosocial life skills: problem-solving; decision-making; negotiation; critical and creative thinking; interpersonal communication; and other relationship skills, such as empathy.
- *Self-efficacy* is concerned with the confidence of individuals and groups (*collective-efficacy*) in their own skills to affect change.
- *Access* includes financial, geographical, or transport issues that affect access to services and ability to buy products.

Finally, *norms*—as expressed in perceived, socio-cultural, and/or gender norms—have considerable influence. Norms reflect the values of the group and/or society at large and social expectations about behavior. *Perceived norms* are those that an individual believes others are holding and therefore are expected of him or her. *Socio-cultural norms* are those that the community as a whole follows because of social status or cultural conventions. *Gender norms* shape the social views of expected behaviors of males and females.

Examples of Theories and Models that Contributed to the Socio-Ecological Model for Change

As mentioned earlier, theories and models are essential for program planning because they identify and make clear the assumptions behind the development of interventions and strategies. They can help us to formulate communication objectives for programs and determine how to measure them, as well as clarify the reasons why programs succeed or fail (McKee, Manoncourt, Yoon, and Carnegie 2000).

C-Change's Socio-Ecological Model for Change is based on existing theories, models, and approaches from several disciplines, including political science, sociology, psychology, and communication. Through a synthesis of the information included in these theories and approaches, the socio-ecological model proposes several levels of influence to find effective tipping points for change. C-Change developed a table to illustrate the theoretical base of this model and how that relates to finding tipping points. The table in the Appendix (page 25) shows how different theories and models contributed to and were synthesized into each ring of this model. The graphic on the next page, "The Theoretical Base of the Socio-Ecological Model," lists the concepts at each level of analysis.

💡 **Theory Corner: Health Belief Model**

If findings indicate that many of the audience's *perceptions* are not in favor of change (e.g., around buying and using an insecticide-treated mosquito bed net), applying the **Health Belief Model** to develop SBCC interventions can help identify tipping points for change (Glanz, Rimer, and Su 2005).
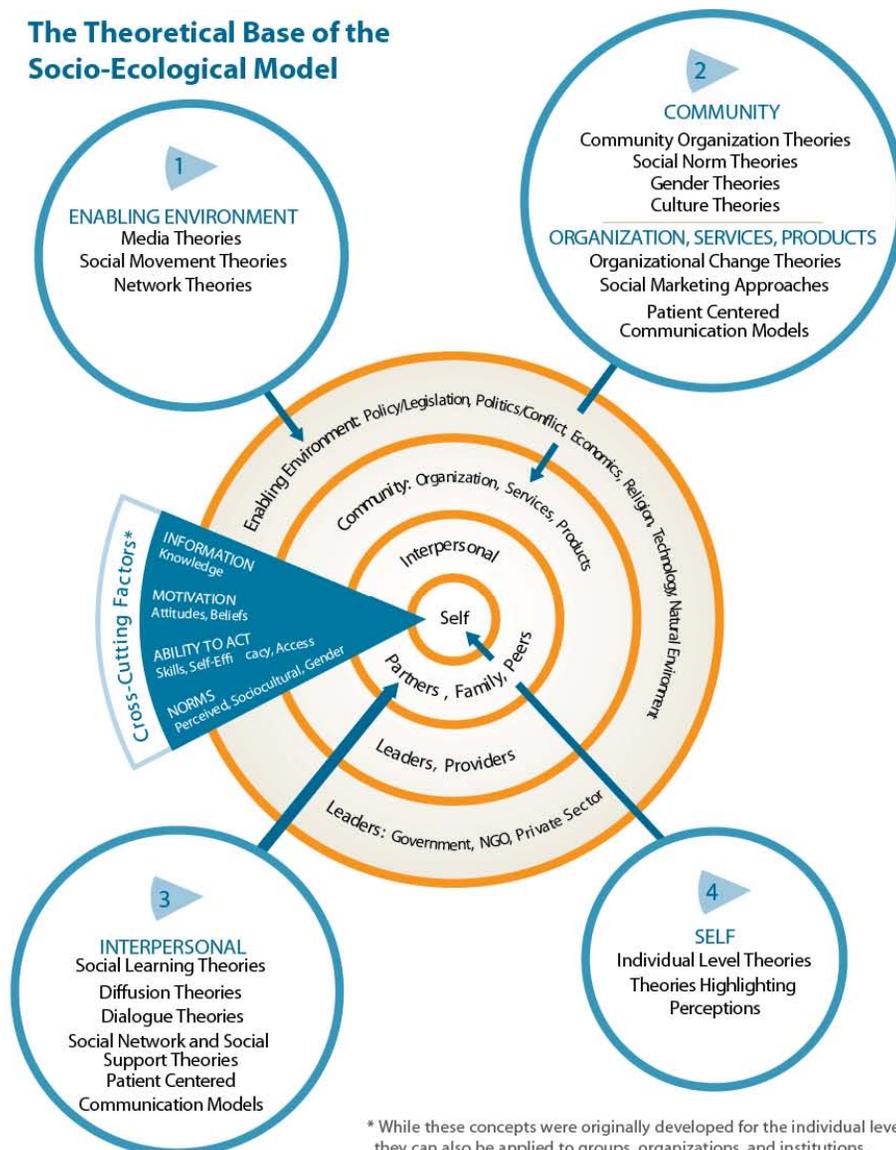
The Health Belief Model claims that beliefs about certain issues can be predictors of behaviors. The model explores perceptions about:
- the possibility of acquiring a health problem (e.g., perceived susceptibility or risk perception for acquiring malaria)
- the risk or vulnerability to the disease (e.g., perceived severity of malaria)
- the effectiveness of taking preventive action (e.g., the belief that a malaria net is effective)
- barriers or costs associated with taking action (e.g., accessing or buying a net)
- one's ability to take action (e.g., self-efficacy in using the net regularly)

The cross-cutting factors in the C-Change's Socio-Ecological Model for Change synthesized the concepts of the **Health Belief Model** and other theories and models (as seen in the graphic on the next page). When looking at it, consider the following questions:
- Which of these theories and approaches sound familiar?
- Which application examples can assist the situation analysis? (More detail is provided in Step 1).
- Which ones could help develop a communication strategy? (More detail is provided in Step 2).

The Theoretical Base of the Socio-Ecological Model

1

ENABLING ENVIRONMENT
Media Theories
Social Movement Theories
Network Theories

2

COMMUNITY
Community Organization Theories
Social Norm Theories
Gender Theories
Culture Theories

ORGANIZATION, SERVICES, PRODUCTS
Organizational Change Theories
Social Marketing Approaches
Patient Centered
Communication Models

Enabling Environment: Policy/Legislation, Politics/Conflict, Economics, Religion, Technology, Natural Environment

Community: Organization, Services, Products

Interpersonal

Self

Partners, Family, Peers

Leaders, Providers

Leaders: Government, NGO, Private Sector

Cross-Cutting Factors*

INFORMATION
Knowledge

MOTIVATION
Attitudes, Beliefs

ABILITY TO ACT
Skills, Self-Efficacy, Access

NORMS
Perceived, Sociocultural, Gender

3

INTERPERSONAL
Social Learning Theories
Diffusion Theories
Dialogue Theories
Social Network and Social
Support Theories
Patient Centered
Communication Models

4

SELF
Individual Level Theories
Theories Highlighting
Perceptions

* While these concepts were originally developed for the individual level,
they can also be applied to groups, organizations, and institutions.

SOURCE : Adapted from McKee, Manoncourt, Chin and Carnegie (2000)

Concepts of Selected SBCC Theories

1

Media Theories
• Agenda setting
• Framing
• Persuasion
• Media advocacy

Social Movement Theories
• Collective action
• Coalition building
• Policy/legislative change

Network Theories
• Diffusion of innovation
• Structures of social networks
• Functions of social networks
  and social support
• Social capital

2

Community Organization Theories
• Empowerment
• Participation
• Catalyst
• Dialogue
• Collective action
• Critical consciousness
• Ownership
• Collective efficacy

Social Norm Theories
• Social norms
• Social convention
• Critical mass
• Tipping point

Gender Theories
• Sexual distribution of labor
• Power & gender inequality as
  social construct

Culture Theories
• Links between culture and structure
• Multiple and shifting contexts
• Cultural relevance/ making meaning
• Community asset

Organizational Change Theories
• Organization development
• Structure of program & services
• Institutionalization

Social Marketing Approaches
• Four Ps: Product, Price, Place, Promotion
• Community based social marketing

Patient Centered Communication Models
• Paternalistic relationship
• Consumerist approach
• Health literacy
• Self- management

3

Social Learning Theories
• Observational learning (modeling)
• Positive/negative reinforcements

Diffusion Theories
• Opinion leaders
• Peer networks

Dialogue Theories
• Consciousness-raising
• Connection

See also: Social Network and Social Support Theories
See also: Patient Centered Communication Models

4

Individual Level Theories
• Knowledge*
• Motivation*
• Attitudes*
• Beliefs*
• Values*
• Past experience
• Psychosocial and life skills
• Self-efficacy
• Accessibility
• Perceived and subjective norms
• Cues to action

Theories Highlighting Perceptions
• Perceived barriers
• Risk perception/vulnerability
• Perceived severity of disease
• Perceived effectiveness of solution
• Perceived benefits of action

* While these concepts were originally
developed for the individual level, they can be
applied to groups, organizations, and
institutions.

ALBANIA EXAMPLE: Using a Socio-Ecological Model to Examine How a Young Woman Relates to Her Environment

Besa is a 21-year-old university student in Albania. She has been in a steady sexual relationship with her boyfriend, Artan, for the past year. For most of their relationship, they have relied on withdrawal, occasionally using condoms that Artan took the initiative to buy. Although the couple hopes to one day start a family, they both agree that now is not the time. They also both agree that they need to find a more reliable and convenient way to prevent Besa from becoming pregnant, as they cannot afford to have a baby. During one of Besa's recent bus rides home, she noticed an advertisement for an oral contraceptive pill for women. The advertisement said that hormonal contraceptives are safe and reliable. She's been contemplating bringing up this option with Artan, since it might allow them to have worry-free sex.

What levels and factors of the model might affect Besa's decision-making process in discussing and pursuing this option with Artan?

Self	Partners, Family, Peers	Community, Services, Products	Enabling Environment
• Level of knowledge about modern contraceptives • Ability to discuss consistent contraceptive use with her partner (self-efficacy) • Perceived barriers to buying modern contraceptives from pharmacies • Self-efficacy in using the contraceptive • Motivation she feels to address the issue • Attitudes toward modern contraceptives	• Common family structure in Besa's community (e.g., mostly stable, married, or long-term couples, vs. single-parent or unstable households) • If family discussions on reproductive health take place (social norms) • What Besa's friends do to prevent accidental pregnancies (social norms) • If it is common for young Albanian couples to use modern contraceptives (social norms) • What Besa perceives her friends and relatives think about contraception practices (perceived norms) • Besa's ability to communicate this option to Artan, knowing that he likes to be the dominant person in their relationship (interpersonal communication skills) • Besa's ability to gather feedback from her friends on their experiences with modern contraceptives (skills) • Social perceptions about the use of modern contraceptives (social norms)	• Availability and accessibility of information on modern contraceptives • How and what the pharmacist tells Besa and Artan (client-provider communication) • Structure of services (availability of and openness to consultations with female pharmacists) and pharmacists' attitudes toward modern contraceptives (positive/negative reinforcement). • Besa's ability to save enough money to pay for the contraceptives (access to services and products) • Physical ease of access to modern contraceptives (access to services and products)	• How religious background affects open discussion about contraception (cultural relevance) • How gender norms may reflect negatively on young women who appear to know about details about sexuality and contraception • Price of modern contraceptives (one of the four Ps of social marketing) • Policies that enable or constrain unmarried couples to access modern contraceptives • How print media and internet sources present information on modern contraceptives (framing) • How media advertisements promote this method to young couples (agenda setting)

WORKSHEET: A Socio-Ecological Model for Change

Reflection Question

✧ How does your current work address the rings of this model? Use this worksheet to help think this through. More detail and guidance is provided in Step 1 (Module 1, session 3 and 4, pages 8-15).
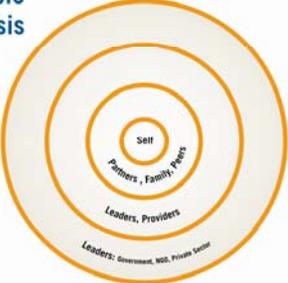
People Analysis	
Context Analysis	
Cross-Cutting Factors	

Characteristic 3: SBCC Operates Through Three Key Strategies

After the situation has been analyzed, the SBCC framework offers an appropriate mix of the following strategies to address change at all levels of analysis. These key strategies are mutually reinforcing:

- *advocacy* to raise resources and political/social leadership commitment for development actions and goals
- *social mobilization* for wider participation, coalition building, and ownership, including community mobilization
- *behavior change communication* for changes in knowledge, attitudes, and practices of specific audiences of programs

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💡 **Theory Corner: There Is a Planning Continuum Among These Three Key Strategies**

Practitioners can begin with any one of the three strategies, depending on such factors as:
- problem being addressed
- policies in place to deal with it
- the organization and/or resource mobilization already addressing the problem

For example, if leadership isn't ready for advocacy on a certain issue, a program might concentrate instead on building a *critical mass* of a *social network* or *coalition* that can put pressure on leadership through a well-defined *advocacy strategy*. Or, if resources allow, consideration could be given to working with the community on a broad-scale BCC effort linked with a mass media intervention to *set the public agenda.* This could eventually affect leaders' perspectives and engage them and others in a *social movement*.

SBCC should always be linked to services or to products that people can access. If these are not in place, SBCC efforts remain toothless, and communication activities may not have significant impact. The graphic "Three Key Strategies of Social Behavior Change Communication" on the next page illustrates how strategies can fit together.

Community mobilization is a sub-strategy of social mobilization. While social mobilization involves coalition building on certain issues and usually takes place at a national level among civil society organizations, donors, and parts of government, community mobilization can do the same at a community level with similar techniques. Coalitions can be formed among community leaders, spiritual and traditional leaders, women's groups, and other organized segments of the community. Techniques used for social and community mobilization include publicity, public discussions, dissemination of information using mass and community media, and training and/or coordination of stakeholders.

Three Key Strategies of Social Behavior Change Communication
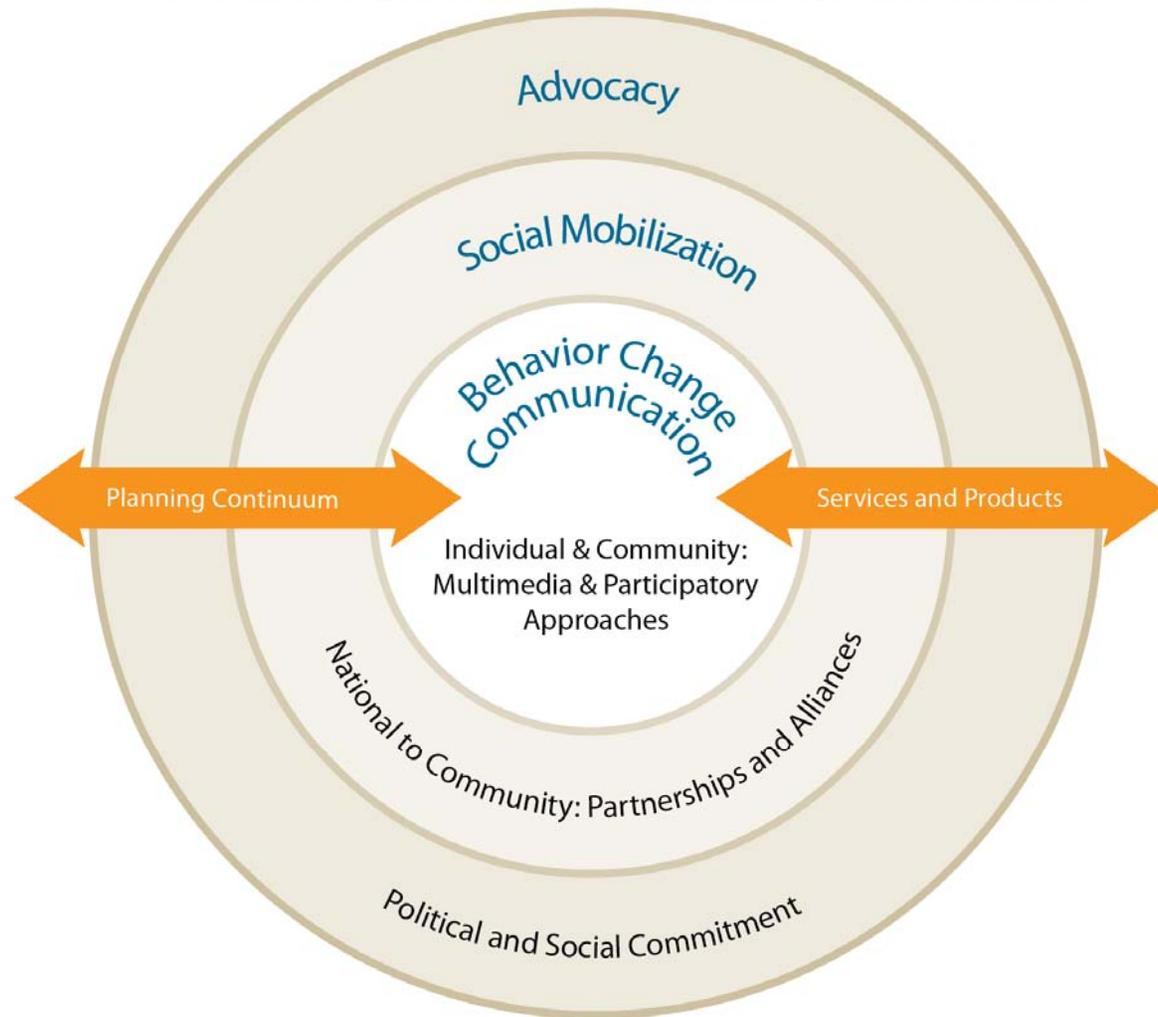
SOURCE: Adapted from McKee, N. Social Mobilization and
Social Marketing in Developing Communities (1992)

WORKSHEET: Key Strategies of SBCC

Directions: Use this worksheet to reflect on the key strategies and how they can contribute to an SBCC program.

Advocacy: To raise resources as well as *political and social leadership commitment* to development actions and goals

- Describe a project you've seen or worked on that included advocacy.

- What do you think is the value of advocacy?

Social mobilization: For wider participation, *coalition building*, and *ownership*, including *community mobilization*

- Describe a project you've seen or worked on that included social mobilization.

- What do you think is the value of social mobilization?

Behavior change communication (BCC): For changes in *knowledge, attitudes, and practices* among specific audiences

- Describe a project you've seen or worked on that included BCC.

- What do you think is the value of BCC?

Three Key Strategies of Social Behavior Change Communication

Advocacy
Social Mobilization
Behavior Change Communication

Planning Continuum — Services and Products

Individual & Community: Multimedia & Participatory Approaches

National to Community: Partnerships and Alliances

Political and Social Commitment

SOURCE: Adapted from McKee, N. Social Mobilization and Social Marketing in Developing Communities (1992)

SOUTH AFRICA EXAMPLE: Combining Advocacy, Social Mobilization, and Behavior Change Communication

December 1998 saw the birth of one of Africa's most powerful HIV and AIDS advocacy groups, the South African Treatment Action Campaign (TAC). It started as a small group of concerned individuals with the aim to *lobby* pharmaceutical companies to drop their prices and put pressure on the government to *revise policy and legislation* to provide free AIDS treatment at state hospitals.

Source [Treatment Action Campaign](#)

Between 1998 and 2008, TAC mobilized people and organizations to campaign for the right to health, using a combination of social mobilization techniques, human rights education, HIV-treatment–literacy support, demonstrations, and litigation. As a result of these campaigns, the price of antiretroviral medicines was reduced, HIV-related deaths were prevented, and TAC helped to force significant additional resources into the health system (Heywood 2009). TAC's *advocacy* campaign of *civil disobedience* in 2003 was only suspended after receiving assurances that a treatment plan was forthcoming.

In 2008, TAC had 250 branches across the country and some 16,000 members in its database. Its strategic objective is to "train and develop a representative leadership of people living with HIV/AIDS on the basis of equality and non-discrimination, irrespective of race, gender, sexual orientation, disability, religion, sex, socio-economic status, nationality, marital status, or any other ground" (Treatment Action Campaign website). Although free access to antiretroviral treatment is now official policy in South Africa, implementation has been spotty. TAC continues to *protest* and sue the government on this issue and to *pressure* industry to make sure workplaces have proper treatment strategies.

TAC's treatment-literacy activities and programs are aimed at individual change and the provision of training and public health education on HIV and tuberculosis for patients and partner organizations, including support-materials development. TAC monitors access to essential services at health facilities. Most recently, TAC's Community Health Advocacy program promotes *women's rights* and mobilizes communities with campaigns to end violence against women.

Reflection Questions

✧   What does this example teach you about the three key strategies of SBCC?
✧   What are your questions?

Module 0, Session 5: Ten SBCC Principles

The following principles can keep an SBCC program on the right track, no matter where it is. While working through the steps of C-Planning, these principles can serve as the compass, especially when programs are faced with challenges and tough decisions.

Principle #1: Follow a systematic approach.

Principle #2: Use research (e.g., operations research), not assumptions, to drive the program.

Principle #3: Consider the social context.

Principle #4: Keep the focus on the key audience(s).

Principle #5: Use theories and models to guide decisions.

Principle #6: Involve partners and communities throughout.

Principle #7: Set realistic objectives and consider cost effectiveness.

Principle #8: Use mutually reinforcing materials and activities at many levels.

Principle #9: Choose strategies that are motivational and action-oriented.

Principle #10: Ensure quality at every step.

WORKSHEET: Ten SBCC Principles

Directions: Use this worksheet to briefly describe and reflect on the ten SBCC principles and where you have seen them in action before.

Ten Principles of SBCC	Reflection Question ✧ Where have you seen these principles in action?
Principle #1: Follow a systematic approach.	
Principle #2: Use research (e.g. operations research), not assumptions, to drive your program.	
Principle #3: Consider the social context.	
Principle #4: Keep the focus on your audience(s).	
Principle #5: Use theories and models to guide decisions.	

WORKSHEET: Ten SBCC Principles, continued

Ten Principles of SBCC	Reflection Question ✧ Where have you seen these principles in action?
Principle #6: Involve partners and communities throughout.	
Principle #7: Set realistic objectives and consider cost effectiveness.	
Principle #8: Use mutually reinforcing materials and activities at many levels.	
Principle #9: Choose strategies that are motivational and action-oriented.	
Principle #10: Ensure quality at every step.	

Module 0, Appendix: The Theoretical Base of the Socio-Ecological Model

C-Change's Socio-Ecological Model for Change is based on a synthesis of theories and approaches from disciplines such as psychology, sociology, communication, and political science. The model allows practitioners to examine and address several levels of influence to find effective tipping points for change. A tipping point refers to the dynamics of social change, where trends rapidly evolve into permanent changes. It can be driven by a naturally occurring event or a strong determinant for change, such as political will that provides the final push to "tip over" barriers to change. Tipping points describe how momentum builds up to a point where change gains strength and becomes unstoppable. *Tipping points* can be important to governments, opposition groups, or social movements to unite people and organizations behind a certain goal and implement actions to propel change forward. The table on the following pages illustrates the theoretical base of the Socio-Ecological Model for Change and how it relates to finding tipping points for change.

What is the purpose of the theory table?
1. The table provides information on theories, models, and approaches that support the relationships proposed by the model.
2. It lists some critical questions that practitioners can consider to determine the value of theories in the situation analysis and decide on possible courses of action to promote change.

How is the table organized?
Each level of analysis (ring) of the Socio-Ecological Model for Change and its theoretical base are represented in the table. For each level of analysis, the following information is provided:
- potential *tipping points* for change and possible key strategies to use at that level of analysis
- selected theories, models, and approaches that apply at each level
- key concepts and foci of the selected theories, models, and approaches
- sample critical questions to guide practitioners' use of theories, models, and approaches during the situation analysis and the development of potential interventions

How is the table used?
Practitioners can use the table to become familiar with and understand the theoretical basis of the Socio-Ecological Model for Change and better apply its perspective to problem solving. The selected theories and critical questions provide guidance and clarification on how the theories and approaches supporting the model can be used during the first two steps of C-Planning: situation analysis and strategy development. The table illustrates how to identify potential determinants of *tipping points* for change; how to address them; and how to determine areas of focus for program activities within the three key strategies proposed—advocacy, social and community mobilization, and BCC—as part of the SBCC framework. Just remember: "Today, no single theory or conceptual framework dominates research or practice in health promotion and education. Instead, one can choose from a multitude of theories" (Glanz, Rimer, and Viswanath 2008).

TABLE: The Theoretical Base of the Socio-Ecological Model for Change

1. Enabling Environment Level

<table>
<tr>
<td colspan="3">
What: Policy/legislation, politics/conflict, economic systems and its state, technology, natural environment, institutions
Who: Government, business, faith and movement leaders, media professionals
Strategies: Advocacy, social mobilization

Possible Tipping Points for Change: Political will, resource allocation, policy change, organizational/institutional development, national consensus/strategy, social movement pressure, and shaping media agenda
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</tr>
</table>

Theories/ Models/ Approaches	Focus	Critical Questions[2]
1.1 Media Theories **Key Concepts** • *Agenda setting* (McCombs and Shaw 1972; Glanz, Rimer, and Viswanath 2008) • *Agenda dynamics*—media agenda, public agenda, and policy agenda (Dearing and Rogers 1996) • *Media advocacy* (Wallack et al. 1993) • *Framing* (Goffman 1974; Iyengar 1991) • *Persuasion* (Perloff 2003)	The mass media can focus attention on issues, helping to generate public awareness and momentum for change. Research on *agenda setting* has shown that the amount of media coverage of any given issue correlates strongly with public perception about its importance. The media tell people what to think about. *Agenda dynamics* refers to the relationship between the media agenda (what is covered), public agenda (what people think about), and policy agenda (regulatory or legislative actions on issues). *Media advocacy* refers to civic actions to shape media attention on a specific issue. It's how, through various techniques, groups that promote social change persuade the media to cover their issues. *Framing* is how issues are presented in news coverage. The same issue can be described in different ways, depending on the narratives and sources used. Experimental research shows that news frames strongly influence how people perceive issues and think about possible courses of action. *Persuasion* is a form of communication seeking to influence attitudes or behaviors without the use of force or coercion.	• How can the media influence public opinion? • How can the media contribute to changes in the enabling environment? • Would increased media coverage of the issue help to change perceptions about its importance among policymakers and the public? • How would increased media coverage affect policy discussion? • How can media coverage of an issue be expanded and changed? • Does it make a difference how the media frames the issue? • How should media decision-makers (e.g., reporters, editors, publishers) be engaged to promote change?

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[2] These key questions coming out of the theories should be considered to help assess the situation and think about possible courses of action to promote change.

Theories/ Models/ Approaches	Focus	Critical Questions
1.2 Social Movement Theories (Tilly 2004) **Key Concepts** • *Collective action* • *Coalition building* • *Policy/legislative change* **Actions:** campaigns, movement repertoire, WUNC displays	Social movements refer to *collective actions* by citizens to promote social changes in policies, laws, social norms, and values. Social movements promote *legislative and policy changes* to advance their causes and *build coalitions* with allied policymakers. They try to find sympathetic legislators to discuss issues and raise awareness and seek to influence the legislative process through mobilization and financial and voting support for allies. To promote change, social movements resort to a combination of different forms of action: 1) *Campaigns:* Long-standing activities to demand specific changes from authorities 2) *Movement repertoire*: Combinations of political action such as coalition building, media statements, rallies, demonstrations, online mobilization, and pamphleteering 3) *WUNC displays*: Participants' concerted public representation of Worthiness, Unity, Numbers, and Commitment Newer social movements in Africa, Asia, and Latin America include faith-based communities, neighborhood and squatter associations, women's and human rights groups, peasant cooperatives, and environmental activists.	• How do social movements contribute to changing the enabling environment around a specific issue? • How does a social movement change policy/legislation around the issue? What policy changes might help bring about overall change? • Is there an existing social movement supporting change related to the issue? What actions has it used? What are its achievements? If there is no social movement, how can one be developed and sustained? • What promotes people's participation around the issue? What collective actions are needed to change the environment? • What collective action strategies have been successful in expressing demands and advancing change in the past?
1.3 Social Network and Social Support Theory (also used at community and interpersonal levels) (McKee, Manoncourt, Yoon, and Carnegie 2000; Glanz, Rimer, and Viswanath 2008) **Key Concepts** • *Structural network characteristics* (reciprocity, intensity, complexity, formality,	The web of social relationships that surround and influence individuals characterizes this theory. Certain *network characteristics*, *network functions,* and *types of social support* make a network effective, e.g., Structure: How extensive is it? Interaction: How strong are the bonds? Density: How well do people know each other? Reciprocity: Are resources and support given and received? The *structural characteristics* of networks refer to aspects such as the degree of homogeneity among members,	• How do social networks influence an individual's knowledge, attitudes, and behaviors (KAB) around the issue? • How might social networks support possible changes? • How can social networks be influenced? • What dimensions (knowledge, attitudes, perceptions) of behavior/social change can be promoted through social networks?

Theories/ Models/ Approaches	Focus	Critical Questions
density, geographic dispersion, directionality) • *Functions of social networks* • *Types of social support*	resource exchange, emotional closeness, formal roles, knowledge, interaction among members, and power and influence among members. The *functions of social networks* refer to social trust, influence, support and criticism, emotional bonds, and aid and assistance. The *types of social support* can be emotional, informational, instrumental, and self-assessment.	
1.4 Social Capital (Putnam 2000) **Key Concepts** • *Institutions* • *Norms and values* • *Trust* • *"Social" resources* (not financial resources)	Social capital refers to the *institutions, norms, and values* of social networks and their impact on social relationships and institutional resources. The theory argues that groups and societies with higher levels of social cohesion and *trust* are fundamental for communities. Links tie people together with others with similar interests and provide bridges to other groups. Social capital refers to the *social resources* that people have and can tap into to engage in economic, social, cultural, and political activities.	• What institutions are adequate platforms to promote change? • How might trust among people promote change? • Where do people gather to discuss common interests? • Who do people trust? Who do they rely on to develop links and engage in different activities?
1.5 Ecological Models **Key Concepts** • *Ecological systems* • *Physical and socio-cultural surroundings* • *Direct effects of environment* • *Intrapersonal factors* • *Interpersonal relations* • *Community factors* • *Institutional factors* • *Public policy*	*Ecological systems* theory suggests that individual behaviors are not only or mainly influenced by psychological factors. They are interdependent with the social context—or anything outside individuals, such as social norms, *interpersonal relations,* culture, and laws and regulations. Individual-level interventions should always take other influencing factors into consideration. Programs need to understand how changes at the level of *neighborhood, community, institution, and social/political structure* might affect individual changes. The recommendation is to take a multiple-level approach that promotes the same change by tackling various forces of change. For example, an intervention promoting bed net use could include an information campaign stressing benefits with efforts to improve access to low-cost bed nets by improving local production and supply chains or	• What factors in the social context influence individual behaviors? Which ones can be positively affected? • What elements and/or components of the social ecology are more likely to influence individuals? • What evidence shows successful changes of various factors and their impact on individual behaviors and decisions? • Must changes to the social context always have an impact on individual behaviors?

Theories/ Models/ Approaches	Focus	Critical Questions
	requesting government subsidies to provide wider access.	
1.6 Theories of Complexity (Waldrop 1992; Lewin 2000; Morin 2008) **Key Concepts** • *Complex adaptive systems* • *Interacting agents* • *Diversity of agents* • *Self-organization*	Complexity theorists argue that individuals are part of *complex systems* characterized by many *interacting agents.* Human behavior is non-linear and unpredictable because of the number and *diversity of agents* and variables in the system. There are therefore no fool-proof recipes for change. Interventions and activities designed from a complexity standpoint would include *all* of the diverse actors that might be involved with a given issue. For example, an infection control intervention in a hospital should not be limited to infection control staff, but rather include representatives of all the hospital units that can contribute, including housekeeping, nursing, security, and orderlies.	• What system components affect individual behavior around the specific issue? • What system elements can be influenced? • What is the most likely point of entry into the system? • How are systems organized and how do they avoid chaos and disorganization?
1.7 Theories of Change (Kubisch and Auspos 2004) **Key Concepts** • *Outcome map* • *Assumptions* • *Pathway of change/action* • *Logic model* • *Inputs/outputs* • *Intermediate outcomes/impacts* • *Emergent change* • *Transformative change* • *Projectible change*	A theory of change is a "concrete statement of plausible, testable *pathways of change* that can both guide actions and explain their impact" (Kubisch et al. 2002). A theory of change is often made visible with a **logic model**— a visual representation that charts (or maps) a path from the problem to be addressed to the *inputs* (available resources), then *outputs* (activities and participation), to finally arrive at *outcomes* (short, medium, and long-term results) that, ideally, will lead to *impact* (long-lasting change). A theory of change brings underlying *assumptions* to the surface so that the reasoning behind an intervention can be assessed and adjusted, if necessary. Note that a sound theory of change needs to be based on a theory of how change actually happens. From this perspective, practitioners should identify the most likely change and drivers of change in a given system. Programmers need to assess possible *tipping points* of change, their likely impact in the overall system,	• What are suitable pathways of actions to promote change? • What changes relating to specific issues are already occurring in a community? • What likely changes may have positive and negative ripple effects? • What secular trends/emergent changes encourage or discourage proposed changes? • What changes have already occurred in a given community that offer insights into local processes of change?

Theories/ Models/ Approaches	Focus	Critical Questions
	and the feasibility that they can be affected by a program. It is also important to identify *emergent change* (change already occurring, whether planned or unplanned); *transformative change* (critical points that caused major transformations in a given community); and *projectable change* (the kind of change that can be planned and implemented).	
1.8 Behavioral Economics (Kahneman 2003; Thaler and Sunstein 2008) **Key Concepts** • *Rational choice* • *Choice architecture*	*Rational choice* assumes that people are driven to maximize perceived individual benefits. Yet it has been proven that the way choices are structured can affect people's decisions. If offered choice in the form of an opt-out choice (e.g., routine HIV testing to which patients have to actively say "no"), more people may make certain choices of advantage, e.g., for public health. Such choices raise questions about whether individuals make decisions independently from their environments. These concepts also suggest that people make certain choices because they are interested in maximizing time, costs, or other factors when making a selection. People can be primed (led or stimulated) to make certain choices just by the structure of options. The easier the choice, the more likely it will be chosen. *Choice architecture* is the act of nudging people toward more healthful or socially beneficial behavior by designing available choices in such a way that individuals will be steered toward the "right" choice (e.g., placing vegetables or salad at the beginning of a school lunch display and reducing the availability of competing foods that are fattening; displaying condoms in easily accessible places in kiosks and stores).	• How can environments be affected to facilitate desirable behaviors? • What behaviors can be made easier if certain environmental factors are altered (e.g., laws, regulations, presentation, distribution, offerings)? • Are there examples of successful choice architecture in a given community? What lessons can be considered for the design of other choices around desirable changes? • Are choices based on rational thought, self control, or selfishness? Or are choices based on rules-of-thumb, irrationally seeking satisfaction, or spur-of-the-moment decisions? • Is a policy change needed, rather than behavioral appeals? • What incentives and regulations can be put in place and/or promoted to make certain behaviors beneficial or mandatory?

2. Community Level (Structures, Organization)

What: Community structures, organization
Who: Leaders
Strategies: Advocacy, community mobilization, BCC

Possible Tipping Points for Change: Community leadership/buy-in; collective efficacy; network participation; community ownership

Theories/Models/ Approaches	Focus	Critical questions
2.1 Community Organization (Glanz, Rimer, and Su 2005) **Key Concepts** • *Empowerment* • *Community capacity to perform critical tasks* • *Participation* • *Self-determination/ relevance*	Community organization emphasizes social action processes through which communities gain control and decision-making over their lives. Community organization involves *empowerment, self-determination,* and *capacity to perform critical tasks*. *Empowerment* refers to the process by which individuals and communities gain confidence and skills to make decisions over their lives. *Self-determination* refers to the capacity of individuals and of communities to make decisions without interference or influence from other actors. *Capacity to perform critical tasks* refers to the ability to execute actions required to improve conditions.	• What community organizations exist? How are communities organized? • How is power structured around specific issues? • What organizations can be mobilized towards positive change? What organizations may be opposed to change? • What local beliefs and practices are or might be linked to change? • What has been the role of local organizations in local processes of change?
2.2 Integrated Model of Communication for Social Change (Reardon 2003) **Key Concepts** • *Catalyst/stimulus* • *Community dialogue* • *Collective action*	The **Integrated Model of Communication for Social Change** describes how social change can happen through a process of *community dialogue,* leading to *collective action* that affects the welfare of communities as a whole and their individual members. The model describes a dynamic, iterative process that starts with a *catalyst/stimulus* that can be external or internal to the community. This catalyst leads to dialogue within the community that, when effective, leads to collective action and the resolution of a common problem.	• Where do people talk about common problems? • How can dialogue about specific issues be promoted? • What are the barriers to dialogue around specific issues? How can these barriers be addressed? • Are there past examples of how local dialogue affects attitudes, opinions, collective action, and/or decisions? What are the lessons that are valuable for future plans?

Theories/Models/ Approaches	Focus	Critical questions
2.3 Theory of Social Norms (Jones 1994) **Key Concepts** • *Social norms* • *Collective norms* • *Perceived norms* • *Subjective norms* • *Injunctive norms* • *Descriptive norms* • *Stigma*	The rules that a group uses to discriminate between appropriate and inappropriate values, beliefs, attitudes, and behaviors—the "dos and don'ts" of society (Appelbaum 1970). *Social norms* may be explicit or implicit. Failure to conform to norms can result in social sanctions and/or social exclusion. *Collective norms* operate at the level of the social system (social network, community, entire society) and represent a collective code of conduct. Collective norms are not measured by aggregating individual beliefs (Lapinski and Rimal 2005). *Perceived norms* are the result of individuals interpreting and perceiving values, norms, and attitudes that others around them hold. Perceived norms are further distinguished into *injunctive norms*—what ought to be done, similar to *subjective norms* of the **Health Belief Model**—and *descriptive norms*—what is actually done by other individuals in the group and what the perceived prevalence is of the behavior in question (Lapinski and Rimal 2005). *Stigmatization* is a frequent method through which groups establish negative norms, while social norms are reinforced through routine group approval. Social norms vary: they evolve through time and among generations and between social classes and social groups (e.g., acceptable dress, speech, and behaviors).	• What prevalent social norms encourage or discourage proposed changes? • What alternative norms may be emphasized to promote desired changes (e.g., tobacco cessation can be promoted through appealing to social norms about health, economic savings, consideration for the health of relatives, and so on)? • Are there gaps between collective norms and perceived norms (the difference between what individuals perceive to be dominant norms and actual norms)? • Are proposed changes stigmatized? If so, what beliefs underlie stigma? What social norms can be promoted to counter stigma (e.g., real men take care of women)? • Do people have positive or negative views about proposed changes? What are the bases for such beliefs (e.g., religion, culture, economic incentive, policy)? • What do people believe should be the dominant (subjective) norms around proposed changes/issues? • Have there been recent social norm changes in a given community? If so, what are the explanations? Has generational change anything to do with it? What other insights can be drawn from that experience?
2.4 Social Convention Theory (Mackie and LeJeune 2009) **Key Concepts** • *Interdependent decision-making* • *Organized diffusion* • *Critical mass*	Social conventions are at work when an individual follows a social rule because of: 1) expectations that many others follow the social rule; 2) his or her preference to do the same as others; and 3) the notion that compliance is in his or her interest. Influencing social conventions requires effort at the community level. Even if an individual or small family unit	• What social conventions need to be changed? Why do specific conventions persist? • What social networks can be mobilized to promote new conventions? • What social conventions have recently changed in the community? Why? Is there wide public knowledge

Theories/Models/ Approaches	Focus	Critical questions
• *Tipping point* • *Public commitment*	changes its practices, the social convention will still be in place. In the case of female genital cutting (FGC), families may be reluctant to abandon the practice if they think that their daughter will be less marriageable. If the entire community abandons the practice, all daughters will be on a level playing field. For social conventions to change, a *critical mass* of community members needs to agree to the change. The *tipping point* for change occurs when a critical mass of community members adopt the change and make a *public commitment.* In Senegal, the TOSTAN project's basic human rights education for women resulted in community-organized and public declarations of the commitment of the entire community to abandon the practice of FGC.	about those changes? • What factors support social convention? Why do people do it? What would happen if people changed conventions? • What might discourage people from practicing the current convention?
2.5 Theory of Gender and Power (Connell 1987) **Key Concepts** • *Sexual distribution of labor and power* • *Gender inequality as a social construction* • *Gender approaches:* neutral, sensitive, transformative, empowering (Gupta 2000)	*Gender inequality* is a *social construction* that results from long-term processes of socialization and education. *Distribution of work* according to gender norms as well as *unequal pay* produces economic inequalities for women. *Power inequalities* are reflected and perpetuated in conditions that, for example, put women at increased risk for disease (such as HIV and AIDS) because of their inability to negotiate correct and regular use of condoms. Women may also be more vulnerable to illness and death when they cannot access transport to health facilities. Gender approaches aim to meet the different needs of men and women in ways that contribute to power balance and equitable practices. These approaches also seek to find ways to empower women through the acquisition of skills, information, services, and technologies. Depending on the level of change aimed for by programs, gender approaches can be *neutral, gender-sensitive, transformative,* and *empowering* (Gupta 2000).	• What gender inequalities exist around the specific issues? Who makes decisions? How are those decisions linked to broad gender-power divisions? • What factors maintain gender inequalities around specific issues? What factors discourage women from gaining more power? • How can gender-equitable decision-making be promoted? What social norms can be tapped to strengthen women's power? • Are there other areas in a given community where men and women have more equitable relationships? If so, why? • Are there men who don't act like most men around specific issue? If so, why?

Theories/Models/ Approaches	Focus	Critical questions
2.6 Culture-Centered Approach (Airhihenbuwa 1999; Dutta 2007) **Key Concepts** • *Links between culture and structure* • *Multiple and shifting contexts* • *Cultural relevance* • *Local community has agency and expertise* • *Shaming techniques* (Ttofi and Farrington 2008) • *Emotional motivators* • *Community-led commitment to change*	**The Culture-Centered Approach** involves designing change interventions and activities that are consistent with a people's and community's cultural frameworks or *culturally relevant.* Local cultural systems are the basis for the development of meanings (or interpretations) about specific social change issues. This approach recognizes the value of *local and community expertise* and knowledge, and views community members as agents capable of promoting change within their own communities. A culture-centered approach involves inquiry into the preferred modes of communication within a given community—oral, written, mixed, visual, traditional, and mediated modes of communication. A culture-centered approach views local culture as a resource, rather than a barrier to change. When ethical challenges arise, such as domestic violence or the solicitation of sex from young girls by older men ("sugar daddies"), local culture and religious and moral norms can be evoked as a *shaming technique* to appeal *emotionally* to perpetrators to cease their behavior.	• How do communities think about a given issue in terms of their own culture? • How does local culture affect people's beliefs and practices about the issue? • How do people talk/communicate about the specific issue? What are the preferred modes of communication? • Do people have opportunities to talk about a given issue? If so, where and when? Are there obstacles? • What local/traditional values might promote "good" practices and changes?
2.7 The Positive Deviance Approach (Zeitlin et al. 1990; Pascale and Sternin 2005) **Key Concepts** • *Asset-based approach* • *Community ownership of change process* • *Community-based and community-driven design and practice* • *Local expertise and solutions*	The **Positive Deviance Approach** seeks to understand why a minority in a given community practices healthy behaviors then integrates those insights into effective planning. For example, in a community where most children are malnourished, positive deviance would try to analyze why some children are well nourished—those who deviate from the norm in a *positive* way. Reasons could be access to economic resources, social capital, religious beliefs, past experiences, and so on. A basic premise of this *asset-based approach* is that change is *community-based and community-driven*—that is, communities have *local expertise, solutions,* and *resources* (e.g., alternative norms, agents) to promote change.	• Are there people who do not conform to the negative norm? Why do they act in that way? Are there common elements among them? • Is it possible to spread their unique and/or deviant" norms across the community? Are there barriers? How can these be addressed? What will it entail to mainstream deviant positive behaviors? • What resources do communities have to promote desirable changes? How can these resources be mobilized toward positive change? • Who (individuals/groups) may be more inclined or disinclined to promote change? What are the reasons?

Theories/Models/ Approaches	Focus	Critical questions
• *Community capacity* • *Community* as agent, resource, setting, target (McLeroy et al. 2003)	The basic steps of the **Positive Deviance Approach** comprise four Ds: Step 1. Define the problem and desired outcome. Step 2. Determine common practices. Step 3. Discover uncommon but successful behaviors and strategies through inquiry and observation. Step 4. Design an initiative based on the inquiry findings. The results of a **Positive Deviance Approach** never yield a recipe for change, since each community has a different challenge, context, and local expertise. Thus, identifying *community capacity* to promote desirable changes is critical. Capacity refers to *agents* who drive change, *resources* (how), *setting* (where), and *target* (who is the subject of change).	Will informing about examples of positive deviance persuade people who practice undesirable behaviors?

2. Community Level (Services, Products)

What: Services, products
Who: Service, product, and institutional provider
Strategies: Advocacy, community mobilization, BCC

Possible Tipping Points for Change: Product design, access, availability, quality of services, demand, service integration, provider capacity, client satisfaction

Theories/Models/ Approaches	Focus	Critical questions
2.8 Theory of Organizational Change (Glanz, Rimer, and Viswanath 2008) **Key Concepts** • *Organizational development* • *Organizational policies* • *Structure of programs and services* • *Institutionalization*	Understanding how to create change in organizations is a critical aspect of health and development promotion. Organizational theories can provide insight into how to manage the adoption of *organizational policies* or the *institutionalization* of a particular intervention within an organization, and they can help explain how an organization may discourage certain behaviors with its *structure of programs and services.* It is important to understand what drives an organization to change, what demands and leads change, and how change is implemented. The interest of organizations in stability, hierarchy, and predictability may discourage change. The need for renewal, survival, and consolidation may encourage change.	• What organizations are responsible or exercise influence over specific issues (e.g., quality of health services)? • What organizational practices and rules affect a given issue (e.g., service provision quality and hours)? • What organizational policies and dynamics negatively affect a given issue? • How is change possible in a specific organization? Is there a previous example of change? If so, how did it happen? Was it gradual or sudden? What parts of the organization are more likely to be changed? • What may motivate organization members to support change? Who has power over change? • How can changes be institutionalized in the organization?

Theories/Models/ Approaches	Focus	Critical questions
2.9 Diffusion of Innovations (Rogers 2003; for a concise and thorough summary, see Robinson 2009) **Key Concepts** • *Social system* • *Communication channels* • *Opinion leaders* • *Relative advantage* • *Compatibility with existing values* • *Complexity* • *Triability* • *Observability* • *Re-invention*	Diffusion of Innovations is a process by which an innovation is spread in a given population over time. Under the right conditions, innovations (new services, products, best practices) can be successfully introduced, communicated, and adapted at individual, community, and organizational levels For diffusion of innovation to be successful it must have a *relative advantage* or be better than an existing service, product, or practice; *compatible with existing values* (perceived social acceptability); easy to implement and not too *complex*; possible to try (*triability*); and have *observable* benefits. Not everyone in a given community is similarly predisposed vis-à-vis specific changes; people have different attitudes, beliefs, and experiences that affect their disposition to change. When *opinion leaders* in the community support the innovation and communicate their approval, the likelihood and pace of adoption is increased. Individuals often improve, adapt, or *re-invent* an innovation to fit their needs and context. Innovations are more likely to be incorporated if they fit into preexisting needs.	• What attitudes exist toward specific innovations? • Who (individuals, groups) is more likely to adapt the innovation? Who is less likely? Why? • What are the advantages of the given innovation over current practices or uses? • Which opinion leaders strongly support innovations and might be mobilized to provide public support? • Have people already experienced the innovation? If so, what happened? Do people have easy access to try the innovation? • What might be the benefits of adopting the innovation for different groups of people?
2.10 Social Marketing Approach (Andreasen 1995; McKenzie-Mohr 2011). **Key Concepts** • *Four Ps:* product, price, place, promotion • *Community-based social marketing*	"Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of their society" (Andreasen 1995). *Product/practice* is what is being promoted. *Price*/cost is the ease of access and barriers to using the product or practice. Perceived cost may not be identical to actual cost, as people may have the wrong impression about how easy or difficult it is to access the product. *Places*/access points refer to where people might have access to the product—where the product is distributed and made available.	• What are the benefits of a given product? • Why would people try, using, and continuing to use a new product? • What is the cost/price for people to access the product? • How can the product be effectively distributed in the population? Where will people access it? • How can the product be promoted? What appeals, format, and content will attract people's attention and reach them most effectively?

Theories/Models/ Approaches	Focus	Critical questions
	Promotion refers to the information/activities to let people know about products and their characteristics. *Community-based social marketing* (CBSM) relies on formative research conducted in the community to ensure that existing and perceived benefits and barriers are understood prior to the design of an intervention, campaign, or activity. CBSM involves the promotion of both actions and/or products.	
2.11 Models of Patient-Centered Communication Functions (Reeder 1972; Holman and Lorig 2000; Glanz, Rimer, and Viswanath 2008) **Key Concepts** • *Paternalism* • *Consumerism* • *Physician-patient relationship* • *Health literacy* • *Patient self management* • *Social distance* • *Patient preferences for physician and patient roles* • *The 5 As model* (Glasgow, Emont, and Miller 2006)	*Paternalistic physician-patient relationships* with professional distance or *consumerist* (patient as consumer) approaches to physician-patient relationships make a big difference for the patient. The *paternalistic* idea of a hierarchical relationship is still the norm in big parts of the world. By comparison, patient-centered relationships encourage clients to see themselves as *consumers* of health care, while providers are trained to expect more assertive and responsible patients. *Health literacy* is an individual's capacity to obtain, process, and communicate information about health. It is needed for *patient self-management* (e.g., health information-seeking, coping with treatment effects, disease monitoring, navigating referrals). *Social distance* is the number and importance of dissimilarities between providers and clients. It may be based on perceptions or objective indicators that do not necessarily have to match. The concept of *patient preferences* speaks to the fact that patients have varying expectations about their own roles and that of providers, often associated with socio-demographic and cultural characteristics.	• What difference does it make to call patients clients? • What advantages do more assertive patients provide for physicians? • How can physicians encourage patient self-management? • What difference would social distance make to the client-provider relationship? And what difference does a good client-provider relationship make for health outcomes (e.g., adherence to HIV treatment)? • What decisions should be made by the provider, and what decisions can a client make?

3. Interpersonal Level

What: Relationships, interpersonal communication, perceived norms
Who: Partners, family, peers, neighbors
Strategies: Community mobilization, interpersonal communication, BCC

Possible Tipping Points for Change: Social norms, perceived norms, self-efficacy and collective efficacy, network, participation, ownership

Theories/Models/ Approaches	Focus	Critical questions
3.1 Social Learning Theory/Social Cognitive Theory (Bandura 1977, 1997, 2001, 2004; Glanz, Rimer, and Su 2005) **Key Concepts** • *Environment* • *Behavioral capability* • *Perceived facilitators and barriers to change* • *Self-efficacy[3]* • *Reinforcements* • *Observational learning (modeling)*	These theories describe the dynamic interaction of the person, behavior, and the environment in which the behavior is performed. Five key factors can affect the likelihood that a person changes a health behavior: 1) *knowledge* of health risks and benefits; 2) *self-efficacy* (confidence in one's ability to take action and overcome barriers); 3) *outcome expectations* (the cost and benefits of adopting a behavior); 4) *goals* people set (and strategies for realizing them, 5) perceived social and structural *facilitators* and/or *impediments/barriers* to the desired change. The concept of *reinforcement* suggests that responses to a behavior decrease or increase the likelihood of its reoccurrence. In addition, the theories suggest that people learn not only from their own experiences, but by observing others performing actions and the benefits they gain through those actions. This concept of *modeling* has been influential in developing entertainment-education programs.	• How do people come to know about a given issue? • How do people feel about their ability to practice certain actions? Is self-efficacy high or low? • Who influences people's knowledge, attitudes, and behaviors? • What barriers discourage practicing certain behaviors? • How can specific practices be reinforced/reminded/maintained? • Who are credible role models who perform the targeted behavior? • How can collective-efficacy about specific issues be promoted?
3.2 Diffusion of Innovations (Rogers 2003) **Key Concepts**	Since they are recognized as *opinion leaders* in a given issue, specific members of a community may lead by example. Their opinions and behaviors may encourage people to try new behaviors and continue to maintain	• Who are opinion leaders on specific issues in a community or group? • Why are they trusted and followed?

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[3] **Social Learning Theory** and **Health Belief Model** both use this concept.

Theories/Models/ Approaches	Focus	Critical questions
• *Opinion leaders*	practices. Imitation of positive behavior may be the result of people following opinion leaders who are admired and trusted around specific issues. Opinion leaders in one area (e.g., breastfeeding, sanitation practices) are not necessarily influential around other issues.	• Have they introduced new behaviors? If so, what happened?
3.3 Theories of Dialogue (Freire 1993; Walton 1998) **Key Concepts** • *Consciousness-raising* • *Connection*	Dialogue can be more than conversation—it can be conceived of as a respectful orientation toward others and as a way of *raising consciousness* about social realities (including inequality in power and economic relations). A "dialogic" approach of raising awareness through interpersonal contact is the opposite of a one-way education, whereby an expert transmits information to an empty/ignorant receiver/audience (banking model). Dialogic communication aims to achieve empathy and a *connection* that invites reflection and potential action.	• What might a dialogic communication strategy look like? • What should the role of the expert be in communication for social and behavior change? • What activities and processes can facilitate consciousness-raising and connection?

See also 1.4—**Social Network and Social Support Theory** used at environmental and community levels (McKee Manoncourt, Yoon, and Carnegie 2000; Glanz, Rimer, and Viswanath 2008)
See also 2.11—**Models of Patient-Centered Communication Functions** used at the community level (Reeder 1972; Holman and Lorig 2000)

4. Individual Level

What: Identity, perception of self, locus of control **Who:** Individuals **Strategies:** BCC **Possible Tipping Points for Change:** Knowledge, beliefs, values, attitudes, perceived risks, self-efficacy, social support/stigma, personal advocacy, life and other skills	

Theories/Models/ Approaches	Focus	Critical questions
4.1 Hierarchy of Effects Model (Chaffee and Roser 1986) **Key Concepts** • *Knowledge* • *Attitudes* • *Behaviors*	Considers the effects of communication and is based in the practice of advertising. Together, these variables are referred to as KAB (*knowledge, attitude, and behavior*) by many researchers. Different hierarchies involving these KAB variables are a product of different levels of involvement and the range of choices available.	• What knowledge and attitudes might lead to desirable behaviors? • How do we know that specific behaviors might be changed if specific knowledge and attitudes are changed?
4.2 Theory of Self-determination (Osbaldiston and Sheldon 2002) **Key Concepts** • *External motivation* • *Internal motivation*	Motivation to change behaviors happens along a continuum from being controlled by others (*external motivation*) to being able to self-determine (*internal motivation*). Internal motivation leads not only to more enjoyment of a behavior change, but also more persistence to maintain a new behavior.	• Do people feel that they or others control decisions about specific behaviors? • Do people believe they can change or promote changes? What is the basis for those beliefs? • Do people hold fatalistic beliefs about change or do they think that change is possible? • Have people effectively promoted and achieved positive change? If so, which ones?
4.3 Theory of Human Motivation (Maslow 1943) **Key Concepts** • *Hierarchy of needs:* physiological safety, social, esteem, self-actualization	Humans must first meet basic *physiological and safety needs* (food, water, shelter, etc.) before addressing higher needs such as *social relations, esteem, or self-actualization* (e.g., a fulfilling career). In relation to behavior change, Maslow's *hierarchy of needs* provides some reference to understand the barriers to change for any behavior. The theory suggests that we need to consider whether people have basic needs met when planning and designing	• What are people's perceived priority needs? What are their most urgent needs around specific issues (e.g., health, education)? • Do people perceive that the promoted change is important? • Is it possible to present the promoted change in terms of existing perceived priorities?

Theories/Models/ Approaches	Focus	Critical questions
	an intervention. Success may be limited in circumstances and contexts where people are focused on meeting basic needs or have other priorities.	
4.4 Stages of Change/ Transtheoretical Model (Proschaska and DiClemente 1986; Glanz, Rimer, and Su 2005; Glanz, Rimer, and Viswanath 2008) **Key Concepts** • *Pre-contemplation* • *Contemplation* • *Preparation* • *Action* • *Maintenance*	This model focuses on stages of individual motivation and readiness to change behaviors. 1. *Pre-contemplation:* Individual has no intention of taking action within the next six months. 2. *Contemplation:* Individual intends to take action in the next six months. 3. *Preparation:* Individual intends to take action within the next 30 days and has taken some behavioral steps in this direction. 4. *Action:* Individual has changed behavior for less than six months. 5. *Maintenance:* Individual has changed behavior for more than six months.	• What are the different stages across several groups in a community vis-à-vis proposed changes/issues? • Are there any obvious explanations to understand such differences across groups? Why do groups hold different attitudes or why are they in different stages? • How can stage transition be promoted? • What appeals can be mobilized to promote stage change? • What motivates people to act and maintain behavior change? Can those factors be tapped into to promote changes among peoples in other, previous stages?
4.5 Theory of Planned Behavior (Ajzen 1985)[4] **Key Concepts** • *Behavioral intention* • *Attitude* • *Subjective norm* • *Perceived behavioral control (equivalent to self-efficacy)*	This theory posits that *behavioral intention* is the most important determinant of behavior. Behaviors are more likely to be influenced when individuals have a positive attitudes about the behavior; the behavior is viewed positively by key people who influence the individual (*subjective norm*); and the individual has a sense that he or she can control the behavior (*perceived behavioral control*).	• Do individuals want to perform the behavior? How likely are individuals to perform behavior? • Are individuals opposed to the behavior? • Why do some individuals have positive or negative intentions? • Do people feel they can control behaviors? • What might motivate people to have positive attitudes?
4.6 Health Belief Model (Rosenstock 1974; Glanz, Rimer, and Su 2005; King 1999) **Key Concepts** • *Perceived susceptibility*	This model highlights individuals' perceptions of: 1) their vulnerability (*perceived susceptibility*) to a health condition; 2) the *perceived severity* of the health condition; 3) the *perceived benefits* of reducing or avoiding risk; 4) the *perceived barriers* or costs associated with the condition; 5) *cues to action* that activate a *readiness to*	• What populations are at risk? What are their levels of risk? • How can risk perceptions be changed or maintained? • Why do people believe that they are at risk? Why do

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[4] The **Theory of Planned Behavior** is a later and more robust version of the **Theory of Reasoned Action** (Fishbein and Ajzen 1975, 1980).

Theories/Models/ Approaches	Focus	Critical questions
• *Perceived severity* • *Perceived benefits* • *Perceived barriers* • *Readiness to act* • *Cues to action* • *Self-efficacy*	*change;* and 6) confidence in ability to take action (*self-efficacy*). In the case of HIV prevention, individuals must • believe they are at risk for HIV and AIDS • believe that HIV and AIDS are serious and deadly • believe that avoiding HIV and AIDS is both worthwhile and possible • feel and be able to take preventative measures	some people believe they are not at risk? • How do risk perceptions match objective risk (the statistical probability of being at risk)? • What perceived barriers and perceived benefits for practicing specific behaviors exist? • What actions can be promoted to reduce risk and risk perception? • Are there groups who seem ready to change/practice new behaviors? • Do people feel they are capable of changing behaviors? • Do people understand how change is possible—what needs to happen?

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Additional Reading

These references provide additional information for SBCC practitioners. The entire SBCC curriculum, references cited below, and additional resources are available at http://www.c-changeprogram.org/our-approach/capacity-strengthening/sbcc-modules. For more resources and opportunities to strengthen capacity in SBCC, visit C-Change's Capacity Strengthening Online Resource Center at http://www.comminit.com/c-change-orc. Graphics in the *C-Modules* can be accessed online, expanded, and shown to participants on a large poster board or through a PowerPoint presentation.

Background Reading

Topic	Item
SBCC	***Sexual Behavioral Change for HIV: Where Have Theories Taken Us?*** Provides a brief overview of theoretical models of behavioral change, a review of key approaches used to stem sexual transmission of HIV, a summary of successful interventions targeting specific populations at risk, and a discussion of remaining challenges.
	Theory at a Glance: A Guide for Health Promotion Practice. Provides information and examples of influential theories of health-related behaviors, the processes of shaping behaviors, and the effects of community and environmental factors on behavior.
Advocacy and/or Social Mobilization	***Moments in Time: HIV/AIDS Advocacy Series.*** Highlights some advocacy moments of many HIV and AIDS global efforts from the perspectives of those involved. Intended to be used as a companion to other trainings
Gender	***Inner Spaces Outer Faces Initiative (ISOFI) Toolkit: Tools for Learning and Action on Gender and Sexuality.*** Provides guidance based on the experiences of CARE staff under the ISOFI project in a toolkit that aims to help health and development staff and organizations understand gender and sexuality and their relationship to reproductive health.

Curricula/Training Materials

A Field Guide to Designing a Health Communication Strategy. Provides practical guidance on designing, implementing, or supporting a strategic health communication effort, with an emphasis on developing a comprehensive, long-term strategy that responds appropriately to audience needs.

Behaviour Change Interventions and Communications: A Learner-Driven Training Programme Piloted in Botswana. Offers assignments, readings, and worksheets in a 10-module course on a full range of behavior change interventions and communications subtopics, including assignments on gender and explanations of key concepts in gender education, gender analysis, and equity promotion. Participants work through issues such as HIV and AIDS and the national response, research tools, communication strategies, and monitoring plans.

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